Building Workforce Bridges across Northwest States:

A Regional Analysis of Workforce Assessments from Six NW States

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Executive Summary

This report is a compilation and analysis of the workforce assessment reports from five of the six states in the Northwest region, which include Alaska, Idaho, Montana, Oregon, Washington and Wyoming. This report is intended to describe the assets and common training needs of people working in public health practice across the six Northwest states so as to encourage resource and idea sharing, the creation of meaningful training curricula, and the development of technology and infrastructure that supports life-long learning for public health practitioners.

Statewide public health workforce assessments were conducted in each of the five Northwest states (Idaho, Montana, Oregon, Washington, and Wyoming) with some conducted as early as 1997 and others conducted or updated in 2001. Each state performed an independent workforce assessment that was suitable for the timing, available expertise, most acceptable approach, and individual population of public health workers in their state. A qualitative meta-analysis method deemed the "minimum database" was used to find the least common denominator that could be identified from among the data described in each of the five states assessment reports. The following five categories for comparative analysis emerged: a) knowledge deficits/unmet training needs, b) preferred mode of receiving training, c) preferred length of training, d) barriers and e) strengths and resources.

The following common findings were identified from the five analyzed reports:

A. Knowledge Deficits/Unmet Training Needs

A majority of the states mentioned the need for improved *communication* as vital in developing and maintaining relationships or coalition-building with external constituents in order to influence public policy. Respondents were also interested in learning how to communicate with internal constituents, within their own agency, for purposes of team-building and interdisciplinary work.

Public health practitioners also identified *administrative skills/ management/ supervision*, as a priority need. Two specific areas of interest emerged—management and supervision skills related to personnel issues and administrative skills related to policy administration. Respondents explicitly requested training in "budgeting," supervising personnel and financial planning.

Respondents identified their need for additional training in *Public Health 101*. Specifically, the workforce expressed their need to understand the historical structure and interaction of the public health and health care systems. They also expressed their desire to learn how to perform community assessments and basic research, design surveys, analyze data, discern trends and evaluate programs.

Lastly, the public health workforce expressed interest in attaining more *computer training* and *technology skills*—learning how to use specific programs and learning how to conduct Internet research. One state was particularly interested in using information technology to collect, analyze and evaluate data and to identify gaps in data.

B. Preferred Mode of Receiving Training

Although, the majority of the states mention on-site, in-person training as their preferred mode of learning, the surveyed workforce also recognized that cost and lack of time are barriers to this option. Traveling long distances in order to participate in training opportunities was a problem for many public health professionals. Therefore, respondents expressed the use of regional

meetings, satellite downlink programs and training via on-line computer courses as important and acceptable alternatives to on-site and in-person training.

C. Preferred Length of Training

Since limited time and limited staffing were mentioned as barriers to taking advantage of training opportunities, surveyed and interviewed respondents were particularly concerned about the duration of a given training. Their preference was that training be offered in a condensed time period such as one or two day workshops. They also indicated that attaching training opportunities to other meetings or conferences is often preferred.

D. Barriers

There was a consensus across the five states that *lack of funds* because of the high cost of most training and lack of tuition reimbursement, was one of the primary barriers to accessing training. Other barriers included: 1) geographic isolation—traveling from remote areas within the state to attend a central training can be both difficult and expensive; 2) limited back-up for staff, especially in smaller offices and local health departments; 3) limited time— workloads were very heavy and most people do not have backup staffing for their job and 4) internal politics in regards to obtaining request to attend training.

E. Strengths and Resources

Workforce assessment respondents described *technology* as being an emerging asset in their states' public health practice setting. The technology described included increased computer and Internet availability in the local districts, development of a satellite and telemedicine networks and the ability to connect easily outside the state via audio and video teleconferencing. Another strength included existing *training opportunities and conferences*; however, the training offerings are often specific to technical areas in specific disciplines and are often not tailored to the general needs of the public health professional. There was also concern that training is often very expensive in terms of actual tuition costs, travel and leave time for staff, and lost revenue for staff who are in bill-for-service activities. Lastly, some respondents indicated there was strong *infrastructural and philosophical support* for workforce development and training that existed in their state.

Based on these findings, the following list of recommendations are suggestions for developing strategies to best meet the needs of the public health workforce in the six NW states:

- *Identify and use existing training opportunities* available within the Northwest region to maximize collaboration and to reduce duplicate efforts.

- Offer and support *distance learning* training as an alternative to on-site training, when appropriate.

- Find opportunities to *integrate workforce development* issues with other public health improvement issues.

- Link Northwest regional workforce efforts with other regional efforts for purposes of *sharing products and strategies* on a national level.

- Utilize information and results from this report to *solicit additional funding* while *maximizing current funding* from CDC and federal bioterrorism grants.

- Solicit specific information from individual states about the *content and intent of requested training* and determine how the training will link to improved performance before developing curriculum.

- *Explore other areas of workforce development* other than "training" in order to include "learning," "mentoring" and "succession planning."

Building Workforce Bridges across Northwest States

Background

In recent years issues related to public health workforce development have received growing attention due to factors that include an aging public health workforce and increasing difficulties in recruiting and retaining a well-trained public health workforce. A natural first step in workforce development involves performing a need assessment to identify the most urgent concerns of the public health workforce. This report is a compilation and analysis of the workforce assessment reports from five of the six states in the Northwest region. These states are each represented in a public health workforce development network convened by the Northwest Center for Public Health Practice (NWCPHP). Recognizing the need to maximize scarce resources and avoid duplication of services related to the workforce, the NWCPHP, located at the University of Washington, developed a cooperative network of Northwest states to address the issue of public health development. The states in this network include Alaska, Idaho, Montana, Oregon, Washington and Wyoming.

Purpose

This report is intended to describe the assets and common training needs of people working in public health practice across the six Northwest states so as to encourage resource and idea sharing, the creation of meaningful training curricula, and the development of technology and infrastructure that supports life-long learning for public health practitioners.

Methodology

State wide public health workforce assessments were conducted in each of the six Northwest states with some conducted as early as 1997 and others conducted or updated in 2001. The NWCPHP was able to support many of these assessments with funding and technical support from the Health Resources and Services Administration (HRSA). Each state performed an independent workforce assessment that was suitable for the timing, available expertise, most acceptable approach, and individual population of public health workers in their state. (*See Appendix 1 for a profile of the public health system in each of these states*). The consultant who conducted the Idaho assessment, for example, used a series of key informant and focus group meetings with members of the public health workforce to identify pertinent data while state employees, conducting the Montana assessment, sent questionnaires to individuals in local, state, and tribal health organizations and to legislators.

A qualitative meta-analysis method deemed the “minimum database” was used to find the least common denominator that could be identified from among the data described in each of the five states assessment reports. The following five categories for comparative analysis emerged: 1) knowledge deficits/unmet training needs, 2) preferred mode of receiving training, 3) preferred length of training, 4) barriers and 5) strengths and resources.

Data Collection

This report provides a review of data collected from November 1997 to February 2001. The workforce population in the assessments that were conducted involved a cross-section of the public health workforce at varying *levels* in their agencies, from different *types* of agencies, and representing multiple *discipline* areas. The following groups were represented in at least one of each of the state assessments:

Workforce Disciplines or Specialty areas:

- nutrition & WIC
- information technology
- nursing
- mental health
- environmental health
- public administration
- animal control
- laboratorians
- epidemiologists & disease investigators
- community organizers
- health educators
- occupational health specialist
- behavioral researcher
- biostatistician
- auditor, inspector or surveyor
- consumer health professionals
- health care consultant
- health planner/policy analyst

Workforce Agencies:

- public health laboratories
- state health departments
- local health departments
- environmental health agencies

Workforce Levels:

- front-line staff
- first level supervisors
- program directors
- administration/management
- health officers
- medical clinicians
- non-medical clinicians

Below is a chart and summary of the approaches each state took in assessing their public health workforce training needs:

Alaska	Idaho	Montana	Oregon	Washington	Wyoming
Awaiting report from state representative	Key informant interviews & focus groups	Survey questionnaire, informant interviews and statewide forum	Key informant interviews and analysis of formal & informal assessments that had been previously conducted	Survey questionnaire, analysis of previous needs assessments, and key informant interviews	Survey questionnaire

Alaska
Awaiting report from state representative

Idaho
An outside consultant employed by the NWCPHP conducted an assessment between December 2000 and February 2001 using a series of key informant and focus group meetings with members of the public health workforce. Twenty focus group sessions were held, including one for each of the seven state bureaus in the Division of Health, one or two with each of the seven local public health districts, and one with each of the three statewide councils composed of program directors from each local district.

Key informant interviews were held with the director of each state bureau and the director of each local district. A total of 34 interviews and focus groups were held, which included 135 members of the Idaho public health workforce. Local district focus group participants included front-line staff, first-level supervisors, and program directors. State bureau focus groups included program directors and special personnel.

Each group discussed the following four questions:
1. What resources already exist for meeting your ongoing professional development needs?
2. What do you think are the biggest training needs in your public health agency?
3. What kind of training methods best help you learn?
4. What barriers, if any, make it difficult to take advantage of training opportunities?

Montana
The NWCPHP, under contract with the State of Montana, conducted a statewide workforce assessment that was completed in November of 1999. Two hundred sixty-seven training need assessment questionnaires were sent to individuals working in state and local health departments, as well as tribal organizations, the Department of Environmental Quality, and the legislature. One hundred thirty-two of the 267 people that were sent the training needs questionnaire responded, for a 49% response rate. Those that responded held the following positions: administration/ management, nursing (including administration), sanitation specialist, environmental health specialist, miscellaneous public health services, WIC specialists, dietician, computer specialist, and animal control.

The following questions were included in the survey:
1. What do you think are the biggest training needs in your public health agency?
2. What areas of training would you most like to have if time and money were not an issue or constraint?
3. What training would most benefit your agency's delivery of public health services?
4. What are your major concerns about taking training courses in public health?
5. Can you travel to a class and how far?
6. What factors are most likely to motivate you to take a training class?
7. Do you think your agency will allow you paid time off for training?
8. What do you think are the most difficult or challenging aspects of delivering public health services in your area?
9. Are you familiar with the Core Functions? What training would be necessary in order to do them?
10. – 12. Computer uses/skills and access to computers or the Internet?

Oregon
The Oregon Turning Point Workforce Assessment Project completed a statewide workforce assessment in August 2001. This assessment performed an analysis of interviews conducted among state and local public health administrators and of existing public health workforce

assessments. The Workforce Project coordinator, with the help of the state Turing Point Coordinator, generated questions and used them as guidelines for interviewing directors and program staff in the Health Services section of the Oregon Department of Human Services. Ten state health administrators or program directors, seventeen county administrators, two officers of the Oregon Public Health Association, and the chair of the Conference of Local Environmental Health Specialists (CLEHS) was interviewed. Interviews were conducted in person, on the telephone, and by email. County and local health department administrators were approached over the telephone or via email. County administrators included staff from various disciplines, i.e., nursing, environmental health, public administrator, etc.

The following questions were used as a guide in interviewing the public health workforce in Oregon:

1. Has a formal or informal workforce needs assessment been conducted by your program/county during the last two of three years?
2. Is so what were your findings? Is there a written report?
3. If no assessment has been conducted, how do you assess the needs of the workforce for your programs?
4. Do you have standards against which you assess the workforce needs?
5. What continuing education is provided for your staff? How is it paid?
6. Are you aware of other workforce assessments that are being or have been conducted regarding the public health workforce?
7. Is there anything else about the public health workforce that you think that is important for me to know?

As mentioned previously, additional data consisted of a meta-assessment of existing Oregon public health workforce assessment reports. These included:

- OHD Salary Survey, All county public health staff, Oregon Health Division Community Services, 1999
- Oregon's Nursing Shortage: A public health crisis in the making, Northwest Health Foundation Issue Brief no. 1 April 2001; Health Alert Network (HAN) surveys
- Informal assessments— assessments done by program staff that were not comprehensive— of Oregon Public Health Workforce Assessments including:
    - unofficial assessment of sanitarians by CLEHS chair, Bob Wilson, 2001
    - County Health Departments;
    - ODHS Health Services;
    - Oregon public health programs on the web.

Washington

The NWCPHP analyzed three training need assessment activities undertaken between 1997 and 1999 in the state of Washington and compiled an updated composite assessment of its workforce. The three, previously conducted assessments included:

- Profile and Training Needs Assessment of the Community/Public Health Professionals in Washington State (1997-98), which provided additional information for identifying specific training needs of the public health workforce in Washington state for this analysis,
- Informatics Information Needs and Uses of The Public Health Workforce (1997-98),
- Field Test Summary of the Proposed Standards of Public Health (1999).

The analysis of these was supplemented by a review of recent NWCPHP activities in the state of Montana, the national work on development of public health competencies by Turnock, the work of the CDC/ATSDR Strategic Plan for Public Health Workforce Development, and a review of

the DOH Performance Standards. The NWCPHP's intent was to compare Washington's findings to those in the other states so as to reconfirm that results were congruent with one another.

The NWCPHP also conducted 15 key informant interviews with public health leaders identified by leadership groups. The key informants were representatives of environmental health, public health nursing, and executive leadership, as well as key informants from DOH. Key informants were asked to review specific elements of three earlier studies on workforce development. Informants were also asked these three broad questions to elicit discussion addressing the elements of the update:

1. Whether the composite summary of training areas needed by the workforce was complete?
2. Which were the five most important areas of training needed by the workforce in the next 2-5 years in order for public health agencies to meet the Performance Standards?
3. What training is already in place to address the identified priority areas?

Wyoming

The University of Wyoming, Division of Kinesiology and Health, in collaboration with the Wyoming Department of Health, conducted a survey of their state and local public health workforce in the Spring of 2001. A 91-item need assessment questionnaire was designed and sent to 596 public health employees in Wyoming state. Three hundred eighty-four surveys were returned for a response rate of 64.4%. The target professionals for this needs assessment included public health employees working in mental health, nursing, environmental health, and consumer health professionals.

From May to June 2001, approximately 25 managers/supervisors from nursing, environmental health and mental health also participated in three focus groups, one focus group for each public health discipline. Each focus group was asked similar questions regarding his/her occupational background and experience, analytical proficiency, public health knowledge, communication skills and cultural competency, etc.

Data Limitations

While the integrity of each state was preserved, lack of a common assessment tool and an integrated approach made data interpretation between states very difficult. Each state offered diverse findings from their assessment—some in extreme details, others providing just the essentials. While some states ranked their findings according to the number of respondents, others provided percentages; therefore it was difficult to compare results. To overcome this dilemma, one was able to extrapolate commonalties by identifying the "least common denominator" in each of the five categories (1) knowledge deficits/unmet training needs, 2) preferred mode of receiving training, 3) learning domains, 4) barriers and 5) strengths and resources). A "topic or need" must by identified by at least two of the six states to be considered for this analysis.

Results

Using a qualitative meta-analysis method deemed the "minimum database," the least common denominator for a cross-state analysis was found for each of these five categories: a) knowledge deficits/unmet training needs, b) preferred mode of receiving training, c) preferred length of training, d) barriers and e) strengths and resources.

The intent of this analysis was to identify assets and common training needs across the six Northwest states so as to encourage resource sharing and to create adaptable curriculum packages. The findings are as follows:

A. Knowledge Deficits/Unmet Training Need

The top four training needs identified in the state workforce assessments conducted in the region were 1) communication, 2) administrative skills/management/supervision, 3) computer training/use & technology and 4) overview of Public Health 101. Each of these areas of need was mentioned strongly by public health staff in at least three of the six state assessments.

1. Communications

   Idaho, Montana, Washington and Wyoming identified "communications" as one of their top training needs. While all four states mentioned the need for improved communication as vital in developing and maintaining relationships or coalition building, the context with how communication should be used and to whom differed from state to state.

   Two categories of communication emerged—*internal* and *external communications*. Both Washington and Wyoming expressed interest in learning how to use the media, advanced technology (e.g., electronic communications), and community networks to relay information for purposes of external communication. On the other hand, a primary concern in Idaho, Montana and Washington was learning how to communicate with 1) internal constituents, within ones own agency, for team-building and interdisciplinary work and 2) with external constituents in order to influence public policy. These external constituents included the community members, policy makers, general public health staff across districts, people working at the state and district level, staff working in different programs, and individuals from different local agencies that provide social services.

   A. <u>Internal Communications</u>
   - basic communication skills & coalition-building within districts at lowerlevels, between state and districts, between programs, & between local agencies
   - improving internal communications—team-building and interdisciplinary work

   B. <u>External Communications</u>
   - w/ community & policy makers to influence public policy
   - using media, advanced technology & community networks to communicate information

2. Administrative skills/management/supervision

   Idaho, Montana, Oregon, and Wyoming public health practitioners identified administrative skills/ management/ supervision, as a priority need. Two underlining themes emerged out of this category—management and supervision skills related to *personnel issues* and administrative skills related to *policy administration*. All of the states, with the exception of Wyoming, specifically requested "budgeting" and supervising personnel—"principles of supervision" and changes in personnel rules and regulations—as desired skills to build. Wyoming was primarily interested in financial planning, specifically learning how to conduct cost effectiveness, cost benefit & cost utility analysis and manage information systems for collection, retrieval and use of data for decision-making.

A. Personnel Issues

- performance evaluation
- goal-setting— staff setting goals related to quality service delivery
- "principles of supervision"— supervising personnel
- changes in personnel rules and regulations
- writing job descriptions
- meeting facilitation— at various coalition meetings

B. Policy Administration

- rules & regulations & policy/procedures development
- budgets
- financial planning—conducting cost effectiveness cost benefit & cost utility analysis, managing information systems for collection, retrieval and use of data for decision-making
- working w/ county commissioners

3. Overview of Public Health 101

Idaho, Montana, Oregon and Wyoming identified their need for additional training in Public Health 101. While all four states were interested in learning more about *basic public health concepts*—understanding the historical structure and interaction of the public health and health care systems, only Idaho and Wyoming specifically requested additional training in *public health research* and *epidemiology methodology* (i.e., community assessment, survey design, basic research methods, data collection analysis, discerning trends and program evaluation).

A. Basic Public Health Concepts

- basic public health science skills—understanding historical development, structure & interaction of public health & health care systems
- core public health concepts

B. Public health research/epidemiology methodology

- survey design
- data collection
- analysis
- discerning trends
- basic research methods
- community assessment
- program evaluation

4. Computer training/use & technology

Idaho, Montana and Wyoming expressed interest in attaining more computer training and technology skills. However, the three states varied in their competency and interest. Idaho respondents wanted to learn how to *use specific programs* (i.e., Excel, Access and PowerPoint) and conduct *Internet research* (i.e., navigating the Internet, searching for topics and bookmarking). Wyoming staff, on the other hand, were interested in *data management*—using information technology to collect, analyze and evaluate data and identify gaps in data. Montana shared both Idaho and Wyoming's interests.

A. Use of Specific Programs
- Excel, Access
- PowerPoint

B. Internet Research
- navigating the Internet—searching for topics, bookmarking

C. Data Management
- billing, keeping and analyzing data
- understand data collection process
- transmission capabilities
- computer storage retrieval capabilities

B. Preferred Mode of Receiving Training

The public health workforce in the northwestern states indicated interest in using several different modalities for learning. However, four out of the six states, including Idaho, Montana, Washington and Wyoming, specified that training delivered on-site by an instructor/trainer was virtually always preferred to mediated training via computer, video-conferencing or satellite downlink site. Though the reasons for this preference were not provided one can speculate that professionals prefer in-person training because of its familiarity, or their lack of comfort with technology, especially given that computer training/use of technology was one of the identified priority needs. The correlation between the two still needs to be further examined.

Although, the majority of the states mention on-site, in-person training as their preferred mode of learning, the surveyed workforce also recognized that cost and time are barriers to this option. Since traveling long distances was a reality for many of these public health professionals, regional meetings, satellite downlink programs and training via on-line computer courses were also mentioned as viable options.

Preferred Modalities:	Number of States:
• On-site	Idaho, Montana, Washington, Wyoming
• Regional meetings	Idaho, Washington, Wyoming
• Satellite	Montana, Wyoming
• Video-conferencing	Montana, Washington
• Computer	Washington, Wyoming

C. Preferred Length of Training

Since limited time and limited staffing were mentioned by at least two states as barriers to taking advantage of training opportunities, surveyed and interviewed respondents were particularly concerned about the duration of a given training. Of the three states that responded to this question, Idaho and Montana preferred that training be offered in a condensed time period such as one or two-day workshops. Wyoming and Montana indicated that attaching the training to another meeting or conference could be another viable option.

Preferred Duration of Training:	Number of States:
• 1-2 day workshops	Idaho, Montana
• Meeting/Conference	Idaho, Wyoming

D. Barriers

The top five barriers to receiving training as identified by at least two of the six states are 1) lack of funds, 2) geographic isolation, 3) limited staff, 4) lack of time and 5) politics.

1. Lack of funds
   There was a consensus across the five states – Idaho, Oregon, Montana, Washington and Wyoming— that lack of funds was one of the primary barriers preventing the workforce from accessing training. However, each state cited different reasons for the lack of funds including the high cost of most training and lack of tuition reimbursement for advanced educational activities. In Wyoming, for example, federal funding is population based, so with only 450,000 people in the entire state, funding levels can be quite low. Deciding to spend limited resources on oneself versus on providing services to the community is a perceived conflict.

2. Geographic isolation
   Idaho, Montana and Wyoming identified geography isolation as another barrier to receiving training. Traveling from remote areas within the state to attend a central training can be both difficult, especially during the winter months, and expensive, therefore training via satellite, video-conferencing or computer are other possible avenues for providing training.

3. Limited staff
   Montana, Oregon and Wyoming were concerned with their limited number of staff. There are limited back-up for staff, especially in smaller offices and local health departments, so if one or two person at a time leaves for a particular training, the office cannot function and will need to be closed.

4. Lack of time
   Two states—Idaho and Montana described lack of time as an issue in the workplace. Local and state staff from Idaho stated that workloads were very heavy and most people do not have backup staffing for their job. As a result, lack of time was a big obstacle to attending any training. Front-line staff in Idaho also described how taking time off from work to go to a training, meant taking time away from providing services—clients therefore would not be seen and revenue would be lost to the program.

5. Politics
   While both Idaho and Montana stated politics as another barrier to training, Idaho drew a clear distinction between this as a "real" barrier or a "perceived" barrier. Although local and state polices were described as having been relaxed in the last couple of years— allowing staff to travel out of state and attend conferences or meetings, there is a perception among some responders in Idaho that it would be difficult to get permission to go to training because there are a large number of steps involved and because people expect to get their training request turned down.

Barriers:	Number of States:
• Lack of funds	Idaho, Oregon, Montana, Washington, Wyoming
• Geographic isolation	Idaho, Montana, Wyoming
• Limited staff	Montana, Oregon, Wyoming
• Lack of time	Idaho, Montana
• Politics	Idaho, Montana

E. Strengths and Resources

Three states, including Idaho, Montana and Wyoming, emphasized *technology*—communications networks and access to satellite downlink facilities— to be an emerging strength in their states. In Idaho, all districts and state bureaus have satellite access in their own building. There is also increasing computer and Internet availability in the local districts. Montana has developed a satellite network and telemedicine network because of its rural geographic distances. However, while a majority of the local public health departments have access to the Internet at their workplace, not all the workforce has access or easy access. This may make web-based training difficult for some public health nurses and sanitarians, staff who often have less access to the Internet due to their responsibilities in the field. Wyoming indicated that they had a very strong communication network throughout the state and have the ability to connect easily outside the state via audio and video teleconferencing.

Another strength identified by two of the six states included existing *training opportunities and conferences*. In Idaho, for example, a wide range of conferences and training courses were described, such as various programmatic training opportunities, a management certification course, Environmental Health Association conferences, and Communicable Disease workshops held in Boise, Idaho. Washington state respondents also indicated that there were many specific training opportunities available, however, the training offerings are often specific to technical areas and often are not tailored to the public health professional. (*See Appendix 2 for a list of available training)*. There was also concern that training is often very expensive in terms of actual tuition costs, in travel and leave time for staff, and in lost revenue for staff who are in bill-for-service activities.

Lastly, Idaho and Montana assessments both indicated the strong *infrastructural and philosophical support* for workforce development and training that existed in their states. In Montana, workforce development efforts are closely tied to their overall public health improvement efforts; Montana's goal of "creating a well-trained and competitively compensated workforce" is an integral part of their five-year strategic plan. Idaho supports training by providing the following: flex-time, partial tuition reimbursement for relevant college/university coursework, and a strong emphasis on training sessions and in-service sessions during local staff meetings. Every district in Idaho was described as having some type of higher education available locally. Although there are some barriers that hinder utilization of these resources, the infrastructural and philosophical support provide a foundation for future endeavors for workforce development.

Strengths & Resources	Number of States
• Technology	Idaho, Montana, Wyoming
• Existing training opportunities	Idaho, Washington
• Infrastructural support for training	Idaho, Montana

Recommendations

This report is intended to describe the assets and common training needs of people working in public health practice across the six Northwest states so as to encourage resource and idea sharing, the creation of meaningful training curricula, and the development of technology and infrastructure that supports life long learning for public health practitioners. The following list of

recommendation are suggestions for developing strategies to best meet the needs of the public health workforce in the six NW states:

- *Identify and use existing training opportunities* available within the NW region to maximize collaboration and to reduce duplicate efforts.

- Offer and support *distance learning* training as an alternative to on-site training, when appropriate, since 1) many barriers to training are interconnected and distance learning addresses many of the shortcomings of other modalities—expense, staff travel and release time, and number of staff who could partake in the training and 2) three of the five states have identified technology as an emerging strength within their states.

- Find opportunities to *integrate workforce development* issues with other public health improvement issues. Borrowing the concept from Washington state, Montana, for example, tied their workforce development efforts with their public health community document, "A Strategic Plan for Public Health System Improvement." This public health improvement community document included the concept of "creating a well-trained and competitively compensated workforce" as one of their five key goals for improving the public health system in Montana.

- Use the NWCPHP to act as a liaison to link Northwest regional workforce efforts with other regional efforts for purposes of *sharing products and strategies* on a national level.

- Utilize information and results from this report to *solicit additional funding* while *maximizing current funding* from CDC and federal bioterrorism grants.

- Solicit specific information from individual states about the *content and intent of requested training* and determine how the training will link to improved performance before developing curriculum.

- *Explore other areas of workforce development* other than "training" in order to include "learning," "mentoring" and "succession planning."

Appendix 1

Snapshots: State Public Health Systems

Alaska

The state health agency is the Division of Health within the Department of Health and Human Services. The Section of Nursing supports 21 health centers, which serve more than 200 communities. Alaska has two local health departments: the North Slope Borough and the Anchorage Municipal Health Department. Some public health services, often personal health services, are provided by the Regional Native Health Corporations.

Idaho

Idaho has a regionalized, relatively autonomous local health department system. Primary health-related responsibility within the Idaho Department of Health and Welfare is delegated to the Division of Health. Autonomous local boards of health govern the seven multi-county district health departments.

Montana

Montana provides public health services through local and state public health agencies, tribal health and Indian Health Services, and privately funded organizations. The state has 52 local health departments within its 56 counties, of which 7 serve the major population centers. These local departments may or may not have local boards of health. They work closely with the State Department of Public Health and Human Services. Four counties with no health departments either contract with adjoining counties for public health services or make other arrangements to have coverage.

Oregon

The Oregon Health Division (OHD), within the Department of Human Services, provides resources, technical assistance, and consultation in a wide variety of areas, including medical, epidemiological, and technical and laboratory support. Local governments directly operate the 33 county public health departments and one multi-county health department, with or without a local board of health. In three counties, the local government contracts with private health clinics to perform public health clinical services, and one county has no health department.

Washington

The Washington State Department of Health is a cabinet-level agency that provides resources, technical assistance, and consultation in a wide variety of areas, including epidemiology, risk assessment, and technical and laboratory support. Washington also has a state Board of Health with specific statutory authority for some portions of the health code. The State Department of Health has authority for other portions. Washington has 34 local health jurisdictions providing front-line public health services within its 39 counties (county health departments, city-county health departments, and multi-county health districts). Local jurisdictions provide the bulk of direct services, though state programs retain direct service responsibility where some centralization makes sense. The state and local jurisdictions maintain an active partnership.

Wyoming

Wyoming's system is based on the individual counties, with many of the public health functions retained at the state level. The state health agency, the Division of Public Health, is a component of the State Department of Health. Wyoming has 23 local health districts, 21 of which are county units and 2 of which are city-county departments. All except the two largest are solely public health nursing offices.

Appendix 2

Summary of Available Training Resources Identified by Key Informants in Washington

Communication Skills
- Larry Wallack at PSU for Media Advocacy
- Vince Covello for Risk Communication
- Toastmasters
- Service organizations (Lions, Rotary, etc.)
- Private training firms (Fred Pryor)
- Universities
- Community colleges
- DOH (Renee Guillerie)
- Outside resources from private organizations to get a different perspective (e.g., public relations firms)

Cultural Skills
- Community colleges
- Universities
- University of Washington
- Bob Goodman at Tulane

Teaching/Training
- Health educators
- Universities
- Teaching colleges
- Local and state public health educators

Assessment and Analytical Skills
- Christinne Hale
- Oregon Health Science Library
- Internal local and state department staff working in assessment (e.g., Torney Smith from Spokane Regional Health District)
- Department of Health
- UW Health Policy Analysis Program

Policy Development/Planning
- WSHA/ASPHA conferences (part of meeting agenda topics)
- UW Health Policy Analysis Program
- Jane Reisman- Evaluation Forum (Private Firm- Seattle- for practical program evaluation)

Community Involvement/Mobilization
- Private consultants
- Universities
- Spokane Health Improvement Partnership (Dan Baumgartner)
- University of Kansas Community Toolkit Website (Steven Faucett)
- UW Northwest Prevention Effectiveness Center (Allen Cheadle)

- DOH Office of Health Promotion

Other

- Pacific Institute (Lou Tice) for Organizational Change
- PH Education Leadership Institute (St. Louis University)
- Neil Hann (University of Oklahoma) for leadership
- For social marketing:
    - DOH
    - Nancy Lee (private consultant)
    - University of South Florida
    - Academy of Educational Development, Washington, DC